Rescue My Speech

Pediatric Therapies

Patient Registration Form

Primary Care Physician:		**Phone:**	
Pt's Guardian Email:			
Pt's Full Name:		**Pt's Soc. Sec. Number:**	
Address:		**City/State Zip:**	
Gender:	**Date Of Birth:**	**Age:**	
Parent/ Guardian #1		**Parent/ Guardian #2**	
Soc. Sec. Number:	**Date Of Birth:**	**Soc. Sec. Number:**	**Date Of Birth:**
Home Phone:	**Cell Phone:**	**Home Phone:**	**Cell Phone:**
Emergency Contact:		**Phone #:**	
Primary Ins. Co:		**Phone #:**	
Address:		**City/ State Zip:**	
Insured:		**Relationship:**	
Policy/ Soc. Sec. #		**Group:**	
Secondary Ins. Co.		**Phone #:**	
Address:		**City/ State Zip:**	
Insured:		**Relationship:**	
Policy/ Soc. Sec. #:		**Group:**	

☐ **Check this box if you do not wish to have your medical information discussed with anyone.**

Please list any/all people that you are permitting Rescue My Speech to discuss and/or view your medical treatment with and their relationship to you. If no name is listed, information will only be discussed with patient.

The Information stated above, to the best of my knowledge, is correct and complete. I authorize Rescue My Speech and/or their billing service to bill my insurance of any/all services rendered on the person listed above. I also allow my insurance company to send payments directly to Rescue My Speech. I understand that I am responsible for any co-payments and/or deductibles not covered by my insurance. If for any reason a collection agency is required to collect outstanding funds, I understand that I am responsible for collection fees as well. I authorize Rescue My Speech to release all necessary information to my insurance company. The below signature releases any/all medical records past or present to Rescue My Speech from other providers.

Signature: Relationship: Date: